EXHIBIT Q

Y

Health Care Financing Administration
Office of Legislation

FAX COVER SHEET

March 2, 1998

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RE:	MEDICARE OVERPAYMENT FOR DRUGS
NOTE:	Attached is last year's language from the President's budget bill. The administration is again putting forth this proposal in the FY 1999 budget package. Also attached is a short summary/rationale from last year's budget package. Let me know if you need further info.

PAGES (INCLUDING COVER): 5

PROPOSALS

XIB-79

(a) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended to read as follows:

"(o) ELIMINATION OF MARK-UP FOR DRUGS AND BIOLOGICALS.—

"(1) IN GENERAL.—If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological shall be the lowest of--

"(A) the physician's, supplier's, or other person's actual acquisition cost, as specified in paragraph (2),

"(B) the average wholesale price, as specified by the Secretary,

"(C) the median actual acquisition cost of all claims for the drug or biological for the 12-month period beginning July 1, 1998, adjusted annually and effective on January 1 of each year beginning with 2000, and

"(D) the amount otherwise determined under this part,

less the applicable deductible and coinsurance amounts.

"(2) ACTUAL ACQUISITION COST.--The actual acquisition cost is the physician's, supplier's or other person's cost

based on the most economical case size in inventory on the date of dispensing or, if less, the most economical case size purchased within six months of the date of dispensing whether or not that specific drug was furnished to an individual whether or not enrolled under this part. The actual acquisition cost includes all discounts, rebates, or any other benefit in cash or in kind (including, but not limited to, travel, equipment, or free products).

"(3) BILLING RULES.—

"(A) BILL TO INCLUDE ACTUAL ACQUISITION COST.—If a physician's, supplier's, or other person's bill or request for payment does not include the physician's, supplier's, or other person's actual acquisition cost, no payment shall be made under this part.

"(B) BENEFICIARY PROTECTIONS.—A physician, supplier, or other person may not bill an individual enrolled under this part—

"(i) any amount other than the payment amount specified in paragraph (1) or (4) (and any applicable deductible and coinsurance amounts), or

"(ii) any amount for a drug or biological for which payment may not be made pursuant to subparagraph (A).

"(C) PENALTIES.—If a physician, supplier, or other person knowingly and willfully in repeated cases bills

one or more individuals in violation of subparagraph (B), the Secretary may apply sanctions against that physician, supplier, or other person in accordance with subsection (j)(2).

"(4) DISPENSING FEE FOR PHARMACIES.—The Secretary may pay a reasonable dispensing fee (less the applicable deductible and insurance amounts) to a licensed pharmacy approved to dispense drugs or biologicals under this part, if payment for a drug or biological is made to the pharmacy.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 11237. PAYMENTS TO PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.

(a) COVERAGE IN HOME AND AMBULATORY SETTINGS IN WHICH A FACILITY OR PROVIDER FEE IS NOT BILLED FOR PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking "or" at the end of subclause (II), and

(B) by inserting "or (IV) in a home or ambulatory setting in which a facility or provider fee is not

regardless of whether the primary surgeon elects to use an assistant-at-surgery. **This proposal achieves about $0.4 billion in savings over five years.**

- Create Incentives to Control High-Volume Inpatient Physician Services. Urban Institute research has found wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status, and disproportionate-share status. This proposal would create incentives to encourage physicians with high-volume inpatient practice styles to become more efficient. Effective January 1, 2000, this proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeded 125 percent of the national median for urban hospitals (125 percent in 2002 and thereafter) and 140 percent for rural hospitals. For each physician practicing in hospitals above those limits, 15 percent of each payment would be withheld during the year. If the physicians collaborate to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest at the end of the year. **This proposal achieves about $2 billion in savings over five years.**

- Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists in Home and Ambulatory Care Settings. Medicare currently pays for services provided by physician assistants, nurse practitioners and clinical nurse specialists -- but only in limited settings (primarily rural areas and nursing facilities). Effective January 1, 1998, this proposal would expand coverage to include home and ambulatory care settings in which a separate facility or provider fee is not charged. **The five-year investment for this proposal is about $0.6 billion.**

- Pay Based on Acquisition Costs Subject to a Limit for Outpatient Drugs Prescribed in Physicians' Offices. While Medicare does not have an expansive outpatient drug benefit, it does cover certain kinds of outpatient drugs, e.g., certain specific drugs that are used with home infusion or inhalation equipment and drugs that are prescribed for dialysis and organ transplant patients. Medicare typically pays for these drugs based on the charge submitted by providers, usually physicians or pharmacies. The HHS IG estimates that Medicare currently pays 15 to 30 percent more than what the provider paid for the drug. Effective January 1, 1998, this proposal would eliminate that mark-up by basing Medicare's payment on the provider's acquisition cost of the drug. As a back-stop, payments for a particular drug would not be allowed to exceed the national median cost of that drug. **This policy achieves about $0.8 billion in savings over five years.**

- Improve Access to Chiropractic Services. If a beneficiary chooses to see a chiropractor for Medicare-covered services, Medicare currently requires that the beneficiary get an x-ray demonstrating spinal subluxation (i.e., misalignment) before beginning chiropractic spinal manipulation services. In some cases, this x-ray requirement may hinder a beneficiary's access to chiropractic services. Effective January 1, 1998, this proposal